Commonwealth of Massachusetts
Department of Mental Health

APPLICATION FOR CHILD OR ADOLESCENT CONTINUING CARE SERVICES (June 20, 2003)

INSTRUCTIONS:
This form is for applicants **18 years of age or younger**.

The applicant, his or her parent, legal guardian, or someone assisting the applicant should complete ®**SECTION 1**.

A treating clinician or other person with knowledge of the applicant's history should complete ®**SECTION 2.**

These sections and the signed ®**AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION** must be returned to the Department of Mental Health Eligibility Unit serving the applicant's area of the state.

DMH Eligibility Units:

Western Massachusetts Area Eligibility Determination Unit
P.O. Box 389, Northampton, MA 01061-0389
Phone: (413) 587-6200 Fax: (413) 587-6240

Central Massachusetts Area Eligibility Determination Unit
305 Belmont Street, Worcester, MA 01604
Phone: (508) 368-3390 Fax: (508) 363-1502

Metro Suburban Area Eligibility Determination Unit
P.O. Box 288 – Lyman Street, Westboro, MA 01581
Phone: (508) 616-2186 Fax (508) 616-3599

North East Area Eligibility Determination Unit
P.O. Box 387, Tewksbury, MA 01876-0387
Phone: (978) 863-5077 Fax (978) 863-5095

Metro Boston Area Eligibility Determination Unit
85 East Newton Street, Boston, MA 02118
Phone: (617) 626-8966 Fax: (617) 626-9216

Southeastern Area Eligibility Determination Unit
165 Quincy Street, Brockton, MA 02302
Phone: (508) 897-2000 Fax (508) 897-2024

DMH Information and Referral service: 1-800-221-0053 (regular business hours only)

DMH web site: www.state.ma.us/dmh

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Department of Mental Health

APPLICATION FOR CHILD OR ADOLESCENT CONTINUING CARE SERVICES (June 20, 2003)

SECTION 1: PERSONAL INFORMATION – completed by the applicant, his or her parent, legal guardian, or someone assisting the applicant

1. Name _____ 2. SSN _____
(Last) (First) (Mi) (Social Security Number)

3. Birth Date _____ 4. Gender _____ 5. Race/Ethnicity_____
(MM / DD / YY) (M / F)

6. Parent Name _____7. Legal Guardian (if any) Name_____

8. Parent's Address_____9. Telephone (___) _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

10. Legal Guardian's Address_____11. Telephone (___) _____
(Number and Street) (Apt No) (City) (State) (Zip Code)

12. Child's current address and living situation _____

_____

13. Who has custody of the applicant? a) Legal:_____ b) Physical:_____

14. Primary contact person_____ 15. Telephone (____) _____
(Last) (First) (Relationship)

16. Does applicant speak English? ☐ Yes ☐ No ☐ Limited 17. Does parent speak English? ☐ Yes ☐ No ☐ Limited

18. Parent's literacy in English? ☐ Yes ☐ No ☐ Limited 19. Parent's literacy in native language? ☐ Yes ☐ No ☐ Limited

20. Applicant's Preferred Language/Dialect_____ 21. Citizenship_____

22. Country of origin_____ 23. Length of stay in US_____ 24. Religion_____

25. **HEALTH INSURANCE & INFORMATION** a) ☐No health insurance

b) ☐ No mental health benefit c) ☐ Application Pending d) ☐ Medicare e) ☐ Medicare/Medicaid

f) ☐ Medicaid/MassHealth Card #: _____ g) RID #:_____

MassHealth Provider
h) ☐ HMO _____ i) ☐ Primary Care Clinician Program (PCC) j) ☐ Other_____
(Name of HMO)
k) ☐Private insurance l) Name of Insurance: _____ m) Policy #: _____

n) Name of Policy Holder: _____

o) Name of primary care doctor: _____ p) Telephone: (____) _____

26. **SCHOOL INFORMATION**

a) Current grade in school_____ b) What school does applicant attend? _____
c) Have special education services been provided in the past six months? ☐ Yes ☐ No
d) Does applicant have a current signed Individual Educational Plan (IEP)? ☐ Yes ☐ No

Applicant Name:

SECTION 1, continued:

27. **MENTAL HEALTH CARE PROVIDER (to be filled out by applicant)**
Who provides regular mental health care? If there is no regular provider of mental health care, please use this section to indicate the most recent source of mental health care.

a) Primary Mental Health Provider _____, _____ b) Check if current provider ☐
(Last) (First) (Degree)

c) HMO, Clinic or Hospital name, if applicable _____

d) Address _____
(Number and Street) (Office Number/Location) (City) (State) (Zip Code)

e) Telephone ( )_____ Extension _____

28. **OTHER RECENT MENTAL HEALTH PROVIDERS**
Please list all mental health services received ***during the past 24 months,*** **including hospitalization.** In addition, list any other sources of medical information to be considered in the determination of eligibility. Attach additional pages if necessary.

Name of the mental health provider where services were received (e.g., MD, hospital, agency, clinic)	Type of service (e.g., inpatient, outpatient, day, residential, substance abuse)	Dates of Service

29. WHY ARE SERVICES BEING REQUESTED?

APPLICATION FOR CHILD OR ADOLESCENT CONTINUING CARE SERVICES (June 20, 2003)

Applicant Name: _____

SECTION 2 begins here, to be completed by clinician or other person with knowledge of applicant's history. Individuals who are not clinicians but are completing this section should leave blank any questions when they are not sure about the answers. For assistance, call the Eligibility Unit for your area at the telephone number listed.

Name of person completing this section, credentials, describe how long you have known the applicant:

_____

_____

1. **To be filled out by clinician only (if no clinician is involved leave diagnoses blank):**

DSM IV DIAGNOSIS: PLEASE COMPLETE ALL AXES

PLEASE CHECK ONE: ☐ Provisional ☐ Confirmed

a) AXIS I _____ b) AXIS II _____

_____ _____

c) AXIS III _____ d) AXIS IV _____

e) AXIS V: current GAF _____
lowest GAF _____
highest GAF _____ f) **Date diagnosed** _____

2. Applicant's current medications, dosages and start dates**:**

3. What is the applicant's presenting problem(s), high risk behavior(s)? Please check box(es) and describe:

☐ Suicide attempt	☐ Fire setting	☐ Running	☐ Homicidal behavior
☐ Sexually offending	☐ Assaultive behavior	☐ Self-abusive behavior	☐ Substance abuse
☐ Criminal behavior	☐ Homeless	☐ Family neglect	☐ Family domestic violence
☐ Sexual abuse victim	☐ Physical abuse victim	☐ Other	

Applicant Name: _____

4. What are the applicant's functional impairments? How do the functional impairments relate to the presenting problems and/or diagnosis?

5. What are the applicant's strengths?

6. How many months during the past twelve months has the applicant been functioning at the current impairment level?

7a. How many months do you anticipate that the applicant will continue to experience severe functional impairment?
7b) Why?

8. **HOW ARE THE PRIMARY PROBLEMS BEING ADDRESSED IN THIS COURSE OF TREATMENT?**

Applicant Name:

9. NOTE: The clinician must ask the applicant directly for responses to 9a-d, as appropriate to the applicant's age. When a decision is made not to directly ask the applicant, questions should be asked of the family member or legal guardian.

Name of person supplying information:_____

During the past six months:

a) Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.) ☐ Yes ☐ No

b) Have you felt that you use too much alcohol or other drugs? ☐ Yes ☐ No

c) Have you tried to cut down or quit drinking or using drugs? ☐ Yes ☐ No

d) Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) ☐ Yes ☐ No

Comments:_____

10a. **CULTURAL OR LINGUISTIC PREFERENCES AND ISSUES**
Please comment on cultural/ethnic preferences, including preferred language. What has been the impact of the applicant's and family's cultural or linguistic tradition on receiving or sustaining involvement in mental health treatment?

10b. Is there anything in the applicant's or family's cultural experience or tradition that: Has presented a barrier to the applicant receiving services? Affects the way that services should be provided? If yes to either, please explain

11. **OTHER RELEVANT INFORMATION (e.g. other agency involvement, family circumstances, medical conditions, criminal justice history, if any) Attach additional pages if necessary.**

Applicant Name:_____

AUTHORIZATION FOR DMH ELIGIBILITY DETERMINATION

- I request that the Department of Mental Health (DMH) conduct a determination of eligibility for continuing care services. I have attached signed release of information forms to this application if necessary. I understand that DMH will collect and review medical records as part of the determination of eligibility. I understand that the applicant's name and information about the applicant will be included in a DMH record keeping system.
- DMH may, at its discretion, request a personal interview with the applicant and/or me or a clinical evaluation in circumstances where the available clinical records are not sufficient to make a determination of eligibility.
- In addition, I will be required to disclose information about income and the applicant's insurance and may be charged for services according to ability to pay.
- I also understand that the decision of DMH in determining whether or not the applicant is eligible for DMH continuing care services may be appealed.
- I received a copy of the DMH Notice of Privacy Practices (appended to this application).

_____ Date signed: _____

Authorized Signature (indicate below)

☐ Parent ☐ Legal Guardian ☐ Applicant if 18 years of age ☐ Applicant if emancipated minor

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PERSON ASSISTING APPLICANT

This section to be completed by provider or other person assisting applicant with the application.

Name _____ Relationship_____
(last) (first) (relationship to applicant)

Address _____
(number and street) (apt no) (city) (state) (zip code)

Telephone Number ( ) _____ ( ) _____
(day time) (evening)

TO SUBMIT RELEASE OF MEDICAL INFORMATION FORMS

As part of the determination of eligibility, the Department of Mental Health will review records of all mental health care provided to the applicant during the past 24 months.

1. Please submit one signed *Authorization for Release of Information* form for each provider of mental health care during the past 24 months. If mental health care was provided through a clinic, please identify a primary provider of care at that clinic.
2. In addition, please submit an *Authorization for Release of Information* form for any other clinical information that should be considered as part of the determination of eligibility.
3. Please submit an *Authorization for Release of Information* form for the applicant's Individual Educational Plan, if any.
4. Please double check the accuracy of the provider's name, address, and phone number on each release form. Please make a phone call if necessary to verify information on the *Authorization for Release of Information* form. Correct names and addresses expedite the eligibility review process.
5. Please submit signed *Authorization for Release of Information* forms along with the application if possible.

How many *Authorization for Release of Information* forms are being submitted with this application? ☐

The Department will also review any medical records that the applicant or those assisting the applicant may have in their possession and wish to submit for consideration.

1. Please complete and sign an *Authorization for Release of Information* form for each medical record that is attached to this application in case DMH staff need to clarify information contained in the report.
2. Copies of medical reports cannot be returned so please do not send original copies.

How many copies of medical reports are attached to this application? ☐

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information
One-Way To Department of Mental Health

Name: Other Name(s):

Address: Phone:

Social Security #: Date of Birth:

I authorize the following person, facility or agency:

Name: Attention: Phone:

Street: City/Town: State: Zip:

to release information, either verbally or in writing to the Department of Mental Health (DMH).

DMH Contact Information:

Name: Phone:

Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g. Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & PSTP(s), Physical Exam & Lab Reports, Progress Note(s):

_____
_____
_____
_____
_____
_____
_____

Purpose for the authorization:

☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)

or

☐ Coordinate care ☐ Facilitate billing
☐ Referral ☐ Obtain insurance, financial or other benefits
☐ Other purpose (please specify): _____

A copy of this authorization shall be considered as valid as the original.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH
Authorization for Release of Information (continued)
One-Way To Department of Mental Health

Name of person/facility/agency to release information to DMH:_____

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to the person, facility or agency authorized to release information to DMH. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. This authorization will expire in 12 months unless otherwise specified (specify a date, time period or an event):_____. I understand that once the above information is disclosed it may be redisclosed and no longer protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the person, facility or agency authorized to release information to DMH. However, lack of ability to share or obtain information may prevent DMH, and/or other person, facility or agency, from providing appropriate and necessary care.

_____ _____
Your signature or Personal Representative's signature Date

_____
Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) _____

Specially Authorized Releases of Information (please initial all that apply)

____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, or an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

_____ _____
Your signature or Personal Representative's signature Date

INSTRUCTIONS:
1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate DMH record; copy to individual or Personal Representative.

Commonwealth of Massachusetts
Department of Mental Health
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

Notice Effective Date: June 20, 2003

Version 3

Privacy

The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

DMH is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. DMH must follow the privacy practices as set forth in its most current Notice of Privacy Practices.

This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice

DMH may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that DMH already has as well as PHI that DMH receives in the future. The most current privacy notice will be posted in DMH facilities and programs, and on the DMH website (www.state.ma.us/dmh), and will be available on request. Every privacy notice will be dated.

How Does DMH Use and Disclose PHI?

DMH may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations

The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment – Consistent with its regulations and policies, DMH may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to determine your eligibility for DMH services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. Your PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care.

To obtain payment -- Consistent with the restrictions set forth in its regulations and policies, DMH may use/disclose your PHI to bill and collect payment for your health care services. DMH may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations -- DMH may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., JCAHO).

Appointment Reminders

DMH may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization

DMH is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent DMH has already acted based upon your authorization.

Exceptions

- For guardianship or commitment proceedings when DMH is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, DMH may disclose a limited amount of PHI for the following purposes:
- **Clergy** – Your religious affiliation may be shared with clergy
- **To Family and Friends** – DMH may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate
- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- For specialized government functions such as government benefit programs relating to eligibility and enrollment
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

Your Rights

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from DMH (excluding disclosure that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

*** These requests must be made in writing**

To Contact DMH or to File a Complaint

If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114,
Phone: 617-626-8160, Fax: 617-626-8077.
PrivacyOfficer@dmh.state.ma.us
A complaint must be made in writing.

You also may contact a DMH facility's medical records office (for that facility's records), a DMH program director (for that program's records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the **Secretary of Health and Human Services**, Office of Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA 02203.